Flu Immunization Registration/Release Form

(Please fill out information completely)

Registration Information

Last name	First Name	Middle Initial	Date of Birth	Age

Address	City/State	Zip

Gender: ☐ Female ☐ Male

Home Phone	Cell Phone

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other _____

Last 4 digits of Social Security Number

1. **Is the person being vaccinated sick today? ☐ Yes ☐ No**
2. **Does the person being vaccinated have an allergy to eggs or to a component of the vaccine? ☐ Yes ☐ No**
3. **Does the person being vaccinated have any other serious allergies? ☐ Yes ☐ No**
   If YES Please List: _____
4. **Has the person being vaccinated ever had a serious reaction to influenza vaccine in the past? ☐ Yes ☐ No**
5. **Has the person being vaccinated ever had Guillain-Barré syndrome? ☐ Yes ☐ No**

Services Requested: ☒ ***Influenza (flu shot)***

I have requested vaccination services from the Pinellas County Health Department as indicated above. I have received and understand information provided in the Vaccine Information Statements.

Signature: _____ Date: _____

OR

Name of Legal Representative: _____

Relationship to Client: _____

Signature of Legal Representative _____

OFFICE USE ONLY

Vaccine	Route/Site	Mfg./Lot #
☐ Influenza (Flu 3Y+PF) ☐ High Dose Influenza (65Y+) ☐ Intradermal Influenza (Flu ID)	IM ☐ ID ☐ LDT ☐ RDT ☐	

Date Administered: _____ Nurse Signature: _____

☐ Walk In _____

☐ Drive Thru; # in the car _____

Time Stamp

Form Check/Triage: _____

Dispensing: _____

Check Out: _____

Telephone: (727) 824-6900● 205 Dr. M.L. King Jr. St. No., St. Petersburg, FL 33701●Fax (727) 820-4250